CITY OF DOVER
699 LAKESHORE AVENUE
PO BOX 115
DOVER ID 83825

ACCIDENT REPORT FORM

DATE: _____

Injured Person _____
Job Title _____

Date of Injury_____ Time of Injury _____am/pm

Place Accident Occurred _____
Description of Accident _____
_____
_____
_____
_____

Corrective Action Taken _____
_____
_____

Insurance Company _____
Signature of Injured Person _____
Person Making Report _____
(If different than person injured)
Signature of Person Making Report _____

Time Lost:

DATE	HOURS
_____	_____
_____	_____
_____	_____
_____	_____

Remarks, Diagram, Recommendations, etc.

_____
_____
_____
_____

DATE _____ _____
Signature of Supervisor or Mayor